TAB 28

The UNION LABOR LIFE INSURANCE COMPANY

Incorporated Under the Laws of the State of Maryland
WASHINGTON, D.C.

Home Office: 111 Massachusetts Ave., N.W., Washington, D.C. 20001

A GROUP INSURANCE POLICY

between

THE UNION LABOR LIFE INSURANCE COMPANY (the Company)

and

JOCKEYS' GUILD, INC. (the Policyholder)

Policy Number	C-4186
Policy Effective Date	April 1, 1997 at 12:01 a.m. local time at the head office address of the Policyholder.
Premium Due Date	The first premium is due on or before the Policy Effective Date. Subsequent premiums are due on the 1st day of each calendar month thereafter.
Type of Coverage	Participating Group Health Insurance: Non-Contributory
State of Issue	This Policy is issued in the state of New York and is governed by its laws. If any part(s) of this Policy is contrary to such laws, that part(s) is hereby amended to conform to such laws.

This Policy is issued in consideration of the Policyholder's Application and payment of the first premium. The Company agrees to pay the benefits provided by the terms of this Policy for Members of the Policyholder who are:

1. insured under this Policy, including any extensions of benefits, on the date an eligible expense is incurred; and
2. entitled to such benefits by the terms and conditions of this Policy.

The terms and conditions set forth by the Company on the following or attached pages are part of this Policy as fully as if stated over the signatures below.

NOTICE: THIS POLICY DOES NOT MEET THE REQUIREMENTS OF A LIFE CARE CONTRACT. AVAILABILITY OF THIS COVERAGE WILL NOT QUALIFY A RESIDENTIAL FACILITY AS A LIFE CARE COMMUNITY.

Signed and sealed at Washington, D.C.

Robert A. Georgine
Chairman and Chief Executive Officer

Countersigned By SIGNATURE NOT REQUIRED
Licensed Resident Agent (where required by law)

10462H

TABLE OF CONTENTS

PAGE

PAGE

SECTION 1 - SCHEDULE OF BENEFITS

PERSONS AND DEPENDENTS RESIDING IN THE PPO SERVICE AREA

THE AMOUNT OF INSURANCE OF ANY PERSON OR HIS OR HER DEPENDENT SHALL BE BASED UPON THE FOLLOWING:

FORMS OF INSURANCE — AMOUNT OF INSURANCE PERSONS AND DEPENDENTS

Employees of the Policyholder, permanently disabled members and retired board members have a $250 Deductible.

BENEFITS	PPO PROVIDER	NON-PPO PROVIDER
COMPREHENSIVE HEALTH BENEFIT		
Deductible (per calendar year)		
Persons riding 0-400 mounts	$500 single or family Deductible	$500 single or family Deductible
Persons riding 401 or more mounts	$250 single or family Deductible	$250 single or family Deductible
Coinsurance Rate	100% of PPO Allowance, except for Inpatient surgery, Inpatient Mental Illness, and Inpatient Chemical Dependency.	80% of Reasonable and Customary charges, after Deductible, except for Inpatient Mental Illness and Inpatient Chemical Dependency.
Inpatient Hospital	Paid at 100% of PPO Allowance. Deductible waived.	Paid at 80% of Reasonable and Customary charges after the Deductible and after the Covered Person has paid $1,000 in Covered Medical Expenses for Inpatient Hospital charges during a calendar year; 100% thereafter during the remainder of that calendar year.

BENEFITS	PPO PROVIDER	NON-PPO PROVIDER
Inpatient Surgery	Paid at 80% of PPO Allowance. Deductible applies to Covered Persons with a $500 Deductible.	Paid at 80% of Reasonable and Customary charges, after the Deductible.
Outpatient Surgery	Paid at 100% of PPO Allowance. Deductible waived.	Paid at 100% after Deductible for Covered Persons with a $250 Deductible. Paid at 80% for Covered Persons with a $500 Deductible.
Doctors Office Visits (including specialists)	Paid at 100% of PPO Allowance, after a $15 Copayment, per office visit, Deductible waived.	Paid at 80% of Reasonable and Customary charges, after the Deductible.
Pap Smear	Paid at 100% of PPO Allowance, after a $15 Copayment, per visit. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after the Deductible.
Mammography	Paid at 100% of PPO Allowance, after a $15 Copayment, per visit. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after the Deductible
Spinal Manipulation	Paid at 100% of PPO Allowance, after a $15 Copayment, per visit. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after the Deductible.
Child Health Supervision Preventive and primary care services for children from birth through age 18.	Paid at 100% of PPO Allowance, after a $15 Copayment, per visit. Deductible waived.	Paid at 100% of Reasonable and Customary charges, Deductible waived.
Routine Physical Exams (one examination per 24 months)	Paid at 100% of PPO Allowance, after a $15 Copayment. Deductible waived.	Not Covered
Immunizations	Paid at 100% of PPO Allowance, after a $15 Copayment, per visit. Deductible waived.	Not Covered

BENEFITS	PPO PROVIDER	NON-PPO PROVIDER
Maternity	Paid at 100% of PPO Allowance, confinement for normal pregnancy limited to four days.	Paid at 80% of Reasonable and Customary charges, after Deductible, confinement for normal pregnancy limited to four days.
Doctor Neonatal (inpatient services)	Paid at 100% of PPO Allowance. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after Deductible.
Emergency Medical Treatment Due to Injury or Illness	Paid at 100% of PPO Allowance. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after Deductible.
Ambulance Services	Paid at 100% of PPO Allowance. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after Deductible (up to 100 miles).
Chemotherapy, Radiation Therapy, Physical Therapy and Dialysis Treatment	Paid at 100% of PPO Allowance. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after Deductible.
Home Health Care Services	Paid at 100% of PPO Allowance, up to 100 visits, per 12 consecutive months. Deductible waived.	Paid at 100% of Reasonable and Customary charges, up to 100 visits, per 12 consecutive months. Deductible waived.
Mental Illness		
Inpatient	Paid at 90% of PPO Allowance, after Deductible.	Paid at 70% of Reasonable and Customary charges, after Deductible.
Inpatient Maximum	30 days per calendar year.	30 days per calendar year.

BENEFITS	PPO PROVIDER	NON-PPO PROVIDER
Mental Illness (Continued)		
Outpatient	Paid at 100% of PPO Allowance, after a $25 Copayment, per visit. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after Deductible, $30 per visit.
Outpatient Maximum	30 visits per calendar year.	30 visits per calendar year to $1,500.
Emergency Outpatient	3 visits per calendar year. (Benefits provided for emergency Outpatient charges will reduce the 30 visits per calendar year Outpatient maximum.)	$60 per visit for up to 3 visits per calendar year. (Benefits provided for emergency Outpatient charges will reduce the 30 visits and $1,500 per calendar year maximum.)
Chemical Dependency Inpatient	Paid at 90% of PPO Allowance, after Deductible.	Paid at 70% of Reasonable and Customary charges, after Deductible.
Inpatient Maximum		
Detoxification	7 days per calendar year	7 days per calendar year
Rehabilitation	30 days per calendar year	30 days per calendar year
Per calendar year **Maximum Benefit***	$20,000. $30,000.	$20,000. $30,000.
*Maximum Benefit is only payable for expenses incurred while the Covered Person is eligible for coverage and while the Policy is in force.		
Outpatient	Paid at 100% of PPO Allowance, after a $25 Copayment, per visit. Deductible waived.	Paid at 80% of Reasonable and Customary charges, after Deductible.
Outpatient Maximum	60 visits per calendar year (20 of such visits available for family counseling).	60 visits per calendar year (20 of such visits available for family counseling).

BENEFITS	PPO PROVIDER	NON-PPO PROVIDER
Coinsurance Rate for all other Covered Medical Expenses *(After Deductible is met)*	80% up to the Coinsurance Limit; 100% thereafter for the remainder of the calendar year.	80% up to the Coinsurance Limit; 100% thereafter for the remainder of the calendar year.
Coinsurance Limit	$ 5,000.	$ 5,000.
Out-of-pocket limit *(excluding Deductible)*	$ 1,000.	$ 1,000.
Lifetime Maximum per Covered Person (combined PPO and Non-PPO Covered Medical Expenses)	$1,000,000.	$1,000,000.

SECTION 1A - SCHEDULE OF BENEFITS

PERSONS AND DEPENDENTS NOT RESIDING IN THE PPO SERVICE AREA

Employees of the Policyholder, permanently disabled members and retired board members have a $250 Deductible.

FORMS OF INSURANCE	AMOUNT OF INSURANCE PERSONS AND DEPENDENTS
COMPREHENSIVE HEALTH BENEFIT	
Deductible (per calendar year)	
Persons riding 0-400 mounts	$500 single or family deductible
Persons riding 401 or more mounts	$250 single or family deductible
Coinsurance Rate (after Deductible, where applicable)	
Inpatient Hospital	
Covered Persons with a $250 Deductible	100% of Reasonable and Customary charges, not subject to the Deductible.
Covered Persons with a $500 Deductible	80% of Reasonable and Customary charges after Deductible, and after the Covered Person has paid $1,000 in Covered Medical Expenses for Inpatient Hospital charges during a calendar year; 100% thereafter for the remainder of that calendar year.
Child Health Supervision	100% of Reasonable and Customary charges, not subject to the Deductible.
Outpatient Therapy for Radiation, Chemotherapy and Dialysis Treatment	100% of Reasonable and Customary charges, not subject to the Deductible.
Ambulatory Surgical Center	100% of Reasonable and Customary charges, not subject to the Deductible.

FORMS OF INSURANCE	AMOUNT OF INSURANCE PERSONS AND DEPENDENTS
COMPREHENSIVE HEALTH BENEFIT (Continued)	
Emergency Medical Treatment due to Injury	100% of Reasonable and Customary charges, not subject to the Deductible if Treatment is rendered within 24 hours. 80% of Reasonable and Customary charges, not subject to the Deductible if Treatment is rendered after 24 hours.
Emergency Medical Treatment due to Illness	100% of Reasonable and Customary charges, not subject to the Deductible if Treatment is rendered within 72 hours. 80% of Reasonable and Customary charges, not subject to the Deductible if Treatment is rendered after 72 hours.
Hospice Care 100% of Reasonable and Customary charges after the Deductible, with the following maximums:	
By a Hospital or Home Health Agency	100 visits per 12 consecutive months.
By a licensed social worker	$50 per visit, for not more than one visit per week.
For professional services for rendering emotional support	$50 per visit
For special services	$25 per day and up to a $100 maximum.
For professional services for counseling all family members combined	$50 per visit for not more than 6 visits in the 12-month period after the terminally ill patient's death.
Home Health Care	80% of Reasonable and Customary charges after a $50 Deductible, up to 100 visits at $50 per visit.

FORMS OF INSURANCE	AMOUNT OF INSURANCE PERSONS AND DEPENDENTS
COMPREHENSIVE HEALTH BENEFIT (Continued)	
Private Duty Nursing	80% of Reasonable and Customary charges after the Deductible for the first 60 shifts after a Hospital confinement and 50% thereafter, (one 8-hour shift per nurse per 24-hour period). Limited to a $5,000 maximum amount per calendar year, (other than Hospice Care services by a Private Duty Nurse).
Secondary Surgical Procedure	50% of Reasonable and Customary charges after the Deductible.
Mental Illness	
Inpatient	80% of Reasonable and Customary charges after the Deductible.
Inpatient Maximum	30 days per calendar year.
Outpatient	80% of Reasonable and Customary charges after the Deductible. $30.00 per visit.
Outpatient Maximum	30 visits per calendar year to $1,500.
Emergency Outpatient	$60 per visit for up to 3 visits per calendar year. (Benefits provided for emergency Outpatient charges will reduce the 30 days and $1,500 per calendar year maximum.)
Chemical Dependency	
Inpatient	80% of Reasonable and Customary charges after the Deductible.
Inpatient Maximum	
Detoxification	7 days per calendar year.
Rehabilitation	30 days per calendar year.

FORMS OF INSURANCE	AMOUNT OF INSURANCE PERSONS AND DEPENDENTS
COMPREHENSIVE HEALTH BENEFIT (Continued)	
Chemical Dependency (Continued)	
Per calendar year	$20,000.
Maximum Benefit*	$30,000.

* The Maximum Benefit is only payable for expenses incurred while the Covered Person is eligible for coverage and while the Policy is in force.

Outpatient Maximum	60 visits per calendar year (20 visits available for family counseling).
Maternity	80% of Reasonable and Customary charges after the Deductible. Confinement for normal pregnancy limited to four days.
Coinsurance Rate for all other Covered Medical Expenses *(After Deductible is met)*	80% up to the Coinsurance Limit; 100% thereafter for the remainder of the calendar year.
Coinsurance Limit	$ 5,000.
Out-of-pocket limit *(excluding Deductible)*	$ 1,000.
Lifetime Maximum per Covered Person	$1,000,000.

Both Schedules contain only a brief summary of the time and dollar limits under this Policy. Additional limits apply to benefits. For complete details, please read the benefit descriptions that follow carefully.

SECTION 2 - DEFINITIONS

Defined terms are shown in this Policy with an initial capital letter. The following meanings will apply to these terms when used in this Policy, unless otherwise defined where such term is used.

Ambulatory Surgical Center

A licensed institution whose primary purpose is the performance of surgery, if such institution has:

1. permanent facilities and all equipment necessary for surgery;

2. a staff of one or more Doctors;

3. a medical staff for patient care, if such staff includes registered professional nurses; and

4. a contract with a Hospital for immediate acceptance of patients who require post-operative confinement. Ambulatory Surgical Center does not include a private office or clinic of one or more Doctors.

Board Certified Doctor

A Doctor who is certified by one of the member boards of the American Board of Medical Specialties in the field of medicine that is concerned with the medical condition involved.

Certified Social Worker

An individual performing within the lawful scope of his or her practice, who has:

1. 6 or more years post degree experience in psychotherapy under supervision providing services for Treatment of mental illness. Such supervision must be satisfactory to the New York State Board for Social Work in a facility licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental, nervous or emotional disorders or ailments;

2. 6 or more years post degree experience in psychotherapy under the supervision, satisfactory to the New York State Board for Social Work, of:

   a. a psychiatrist, or a certified and registered psychologist; or

   b. a social worker qualified for reimbursement; or

3. a combination of the experience specified in 1. and 2. above which totals 6 years; such experience must be satisfactory to the State Board for Social Work.

Claim Administrator

The entity assigned to pay claims in accordance with the terms and conditions of this Policy. The Claims Administrator may be the Company, the Policyholder, or a third party with whom the Company or the Policyholder has a valid contract to pay claims.

Company

The Union Labor Life Insurance Company, 111 Massachusetts Ave., N.W., Washington, D.C. 20001.

Cosmetic

Surgery or other Treatment performed primarily to alter and reshape normal body structures in order to improve a Covered Person's looks.

Covered Facility

A Hospital, or any other facility specifically covered under the terms of this Policy.

Covered Medical Expense

The Reasonable and Customary charge for the Treatments which are Medically Necessary. A charge is deemed incurred on the date the Treatment is provided.

Covered Person

A Person or his or her Dependent who is insured under this Policy.

Custodial Care

Care, including confinement, that is given due to a Covered Person's age or mental or physical condition:

1. when there is no active plan of Treatment to improve a Covered Person's physical, functional or mental condition; or

2. when there is an active plan of Treatment, but the Covered Person has attained his or her maximum level of physical, functional or mental ability, and the active plan of Treatment cannot reasonably be expected to significantly improve the Covered Person's condition.

Custodial Care includes, but is not limited to, care given primarily to help the Covered Person in the activities of a normal daily life, such as:

1. helping to wash, bathe, move around, exercise or dress;

2. feeding, including tube or gastrostomy feeding, or preparing meals or special diets;

3. administering an enema; or supervising medication which can usually be self-administered; or

4. acting as a companion or sitter.

The Company reserves the right to review care provided and/or Treatment plans.

The Company may rely on its medical review department and/or an independent medical reviewer to determine if care, including confinement, is Custodial Care. The determination that care and/or confinement is Custodial Care in no way implies that the care or confinement is not required by the Covered Person; it only means that there are no benefits for such care or confinement under this Policy.

Dependent

A Dependent spouse or child of a Person, who is eligible for insurance under this Policy, as determined under *Section 3B, Dependents To Be Insured.*

Doctor

An individual licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

The term "Doctor" shall also include a licensed:

1. dentist; optometrist; podiatrist; psychologist; registered clinical psychologist; psychiatrist; chiropractor; licensed or certified physiotherapist; a licensed audiologist or speech pathologist; and

2. a Christian Science Practitioner, currently listed and certified by the First Church of Christ, Scientist, of Boston, Massachusetts, while such practitioner provides in-person Treatment.

Additionally, the term "Doctor" shall also include any licensed or certified health care provider as required by state law, for services which are:

1. within the scope of the health care provider's license or certificate; and

2. a covered expense.

"Doctor" does not include the Covered Person or his or her parent; guardian; spouse; brother; sister; natural, step, adopted or foster child; grandparent; in-law; or a person residing in the Covered Person's household.

Experimental or Investigational

Any service, procedure, supply, equipment, device, or Treatment, which is not generally accepted by the medical profession or which is listed as experimental, under investigation, or limited to research:

1. by the federal Food and Drug Administration (FDA); the American Medical Association (AMA); Diagnostic and Therapeutic Technology Assessment (DATTA); or the Office of Medical Application of Research of the National Institute of Health Office of Technology Association (OMT); or

2. if a Treatment has not been addressed by one of the organizations listed in 1. above, the Company has the right to determine if a Treatment is appropriate based on the advice of its medical review department and/or an independent medical reviewer and other medical experts.

However, a drug prescribed for the Treatment of a certain type of cancer will not be excluded on the basis that such drug has not been approved by the federal Food and Drug Administration (FDA). Provided, however, that such drug must be recognized for Treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information;
3. the United States Pharmacopeia Drug Information; or
4. recommended by review article or editorial comment in a major peer reviewed professional journal.

No coverage will be provided for any experimental or investigational drugs or any drug which the FDA has determined to be contraindicated for Treatment of the specific type of cancer for which the drug has been prescribed.

Hospital

A facility, or part of a facility, that is operating as a short-term, acute general Hospital, and which:

1. is primarily engaged in providing, by or under the continuous supervision of Doctors, to Inpatients, diagnostic services and therapeutic services for diagnosis, Treatment and care of injured or sick persons;

2. has organized departments of medicine and major surgery;

3. has a requirement that every patient must be under the care of a Doctor or a dentist;

4. provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);

5. if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 186(k) of United States Public Law 89-97 (42 USCA 1395x(k));

6. is duly licensed by the agency responsible for licensing such Hospitals; and

7. is not, other than incidentally, a place of rest, a place primarily for the Treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilatory care; or

8. has a Christian Science sanatorium currently operated, or currently listed and certified, by the First Church of Christ, Scientist of Boston, Massachusetts.

Illness

A disorder or disease of the body or mind. Illness shall include pregnancy, childbirth and related medical conditions.

Injury

Bodily harm that is not the result of disease.

Inpatient

Treatment provided while an individual is confined as a bed patient in a Covered Facility.

Medical Expense Benefits

All benefits under this Policy.

Medically Necessary/Medical Necessity

The Company will determine if Treatment is Medically Necessary. To be considered Medically Necessary, the Treatment must be ordered by a Doctor to diagnose or treat an Injury or Illness and be:

1. generally recognized in the Doctor's profession as effective and essential to the Treatment of the Injury or Illness for which it is ordered; and

2. appropriate for the symptoms and consistent with the diagnosis; and

3. the appropriate level of care, and which:

    a. is provided in the most appropriate setting, based on the diagnosis and condition; and

    b. could not have been omitted without an adverse effect on the Covered Person's condition or the quality of medical care; and

4. based on generally recognized and accepted standards of medical practice in the United States; and

5. not considered experimental, investigatory, or primarily limited to research in its application to the Injury or Illness; and

6. not primarily for scholastic, educational, vocational or developmental training; and

7. not primarily for the comfort, convenience or administrative ease of the Doctor or other health care provider, or the Covered Person or his or her family or care taker; and

8. not Custodial Care.

The Company reserves the right to review medical care and/or Treatment plans.

The Company may rely on its medical review department and/or an independent medical reviewer to determine if Treatment is Medically Necessary. The fact that a Doctor may order Treatment does not, of itself, make it Medically Necessary, or make the expense a Covered Medical Expense.

Medicare

Title XVIII of the Social Security Act of 1965 as amended.

Nursing Home

A licensed institution or a section of a Hospital, primarily engaged in providing convalescent services for sick or injured Inpatients, and which has: (a) continuous nursing service under the full-time supervision of a Doctor or a registered professional nurse; (b) the services of a Doctor available under an established agreement; and (c) clinical records for all patients. Nursing Home does not include a rest home or a place for care of the aged, alcoholics or drug addicts.

Officer of the Company

The President, a Vice President, the Secretary or Assistant Secretary of the Company.

Outpatient

Treatment that is provided when the individual is not confined as a bed patient in a Covered Facility. This will include Outpatient Treatment at a Covered Facility as well as visits to a Doctor or other covered health care provider.

Person

An employee who is in a *Class of Eligible Persons* for insurance under this Policy, as determined under *Section 3A, Persons To Be Insured.*

Policy

The contract, the application, and any subsequent amendment that the Company issues to the Policyholder.

Policy Year

The 12 month period starting April 1 of one year, and ending March 31 of the next year.

Private Duty Nurse

A registered professional nurse or graduate nurse ("R.N."), or a licensed practical nurse ("L.P.N.") or a nurse, currently listed and certified by the First Church of Christ, Scientist, of Boston, Massachusetts, providing in-person services. Private Duty Nurse does not include the Covered Person or his or her parents, guardian, spouse, brother, sister, child, grandparent, in-law or a person residing in the Covered Person's household.

Reasonable and Customary

A charge for Treatment which is the lesser of the following:

1. the usual charge made by the provider for that Treatment; or

2. the prevailing charge made by other providers of similar professional standing within the same or a similar geographic area for that Treatment.

If the usual or prevailing charge cannot be determined, the Company will determine what is a reasonable charge, taking into account:

1. any unusual complications of the Injury or Illness;

2. the complexity and degree of professional skill required; and

3. other pertinent factors.

The fact that a Treatment is determined to be Medically Necessary does not, of itself, mean that the charge will be determined to be Reasonable and Customary.

Treatment

A Treatment or course of Treatment which is ordered and/or provided by a Doctor to diagnose or treat an Injury or Illness, including:

1. confinement and Inpatient or Outpatient services or procedures; and

2. drugs, supplies, equipment, or devices.

The fact that a Treatment was ordered or provided by a Doctor does not, of itself, mean that the Treatment will be determined to be Medically Necessary.

SECTION 3A - PERSONS TO BE INSURED

Classes of Eligible Persons

The following classes of Persons are eligible for insurance under this Policy:

A Person means a Full-Time employee of the Policyholder, if such Person is in one of the following classes:

Class 1 - A Person who:

a. is not a resident of an Excluded State; and

b. is not eligible to become insured under this Policy for Transfer Insurance.

Class 2 - A Person who has Transfer Insurance.

Definitions

"Excluded State" means Vermont and anywhere else except the remaining 49 states of the United States of America, the District of Columbia or Puerto Rico.

"Full-Time" means the active performance for pay or profit of the regular duties of one's normal occupation at a place where such duties are normally performed or other location which travel is required.

"Transfer Insurance" means the Person's insurance or Person's and Dependent's insurance in force under the previous policy.

When a Person First Becomes Eligible

A Person, who is in a Class of Eligible Persons on or after the Policy Effective Date, will be eligible for the insurance provided by this Policy on the later of:

1. the Policy Effective Date; or

2. the first day of the calendar month on or after the Company approves such insurance.

Eligibility is based upon the Person's number of mounts during the previous December 1 through November 30, as set forth by the Policyholder.

For **initial** insurance or **reinstatement** of insurance to take effect, the Person must give the Policyholder a completed, written request for the insurance on a form satisfactory to the Company, as required. A written request for Transfer Insurance must be given within 31 days after the Insurance Date. ("Insurance Date" means the date that **initial** or **reinstated** insurance takes effect as follows: the first day of the month on or after the date the Company approves such insurance.) A written request for **reinstatement** must be given within three months after the date active duty in the armed forces ended. Refer to the provision titled **Reinstatement of Insurance** in this Section of this Policy.

Effective Date of a Person's Insurance

A Full-Time employee will become insured on the date he or she first becomes eligible.

When a Person's Insurance Terminates

Except as provided for extended benefits, a Person's insurance under this Policy will terminate upon the earliest of:

1. the date this Policy terminates;
2. the date the Person is no longer in a Class of Eligible Persons under this Policy;
3. the date premium payments on behalf of the Person cease;
4. the date the Person fails to pay the required premium, if any, when due; or
5. the date the Person enters into full-time active duty with the armed forces of any country.

Upon termination, a Person may be entitled to pay the premium and continue his or her insurance under this Policy. Refer to *Continuation of Coverage Upon Termination* in this Section of this Policy.

Reinstatement of Insurance

1. If a Person's insurance terminates because he or she enters into full-time active duty with the armed forces of any country, it will be reinstated provided the Person submits a written request for reinstatement within three months after the date he or she was discharged from active duty.
2. If a Person's insurance terminates for any other reason, he or she may again become eligible for the insurance by satisfying the requirement for eligibility as a new employee under the provision *When a Person First Becomes Eligible* in this Section.

All Lifetime Maximum Benefits shown on the *Schedule of Benefits* will apply to each Covered Person while he or she is insured under this Policy at any time. If there is a break in insurance, only the portion of any Lifetime Maximum Benefit remaining on the date of termination will be reinstated when insurance resumes.

If insurance resumes within the same calendar year that it terminated, credit will be given for any portion of the Deductible or Coinsurance Limit met prior to such termination.

SECTION 3B - DEPENDENTS TO BE INSURED

Eligible Dependents

Dependents, of Persons in Class 1, who are eligible for insurance under this Policy shall be a Person's:

1. lawful spouse identified on the request for insurance, not a resident of an Excluded State, and not eligible to become insured under this Policy for Transfer Insurance as a Dependent, eligible for Dependent insurance based upon the Person's number of mounts during the previous December 1 through November 30; and

2. unmarried child who is under age 19, not a resident of an Excluded State, except that this requirement does not apply if the Person has Dependent insurance in force for children, and not eligible to become insured under the Policy for Transfer Insurance as a Dependent; eligible for such insurance based upon the Person's number of mounts during the previous December 1 through November 30; and

3. unmarried child who is chiefly dependent upon the Person for support and maintenance and is attending an accredited school as a full-time student. Such child will be considered an Eligible Dependent under this Policy until the earliest of:

   a. the date the child marries;

   b. the date the child ceases to be a full-time student; or

   c. the date the child attains age 23.

As used in this Policy, "child" means the Person's natural child. The term child shall also include:

1. an adopted child; and a prospective adopted child who is dependent upon the Person for support and maintenance during any waiting period prior to the finalization of the child's adoption; and

2. a step-child or foster child, if such child is chiefly dependent upon the Person for support and maintenance.

Dependents, of Persons in Class 2, who are eligible for insurance under this Policy shall be a Person's:

1. lawful spouse identified on the request for insurance; and

2. unmarried child who is less than the limiting age, stated above, on the Transfer date; and

who was insured as a Dependent under the prior Policy and for whom the Person has Transfer Insurance.

"Transfer Date" means, for each eligible Person with Transfer Insurance, April 1, 1997.

Handicapped Child Provision

A Dependent child, whose insurance under this Policy would otherwise terminate solely due to attainment of the limiting age, will continue to be considered an Eligible Dependent while he or she is and remains:

1. chiefly dependent upon the Person for support and maintenance; and

2. incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the Mental Hygiene Law, or physical handicap;

provided:

1. the child became so incapable prior to attainment of the limiting age; and

2. written evidence of the incapacity is sent to the Company within 31 days after attainment of the limiting age; and

3. proof that the child continues to be dependent and incapable is sent to the Company from time to time at its request, but not more frequently than once a year after 2 years from the date the child attained the limiting age stated above; and

4. the Person remains covered under this Policy and the Dependent remains in such condition.

Dependents Who are Persons

A Dependent who is eligible for benefits as a Person under this Policy shall not be considered an Eligible Dependent under this Policy.

If both parents of a Dependent child are eligible Persons, such child will be considered an eligible Dependent of only one parent.

Effective Date of a Dependent's Insurance

A Dependent shall become insured on the date the Person becomes insured. If a Person acquires a Dependent after that date, such Dependent will become insured on the date he or she is eligible as provided under *Eligible Dependents* in this Section.

Exception

A Dependent, other than a newborn child, who is in the Hospital on the date he or she would otherwise become insured under this Policy will not become insured until he or she is finally discharged from the Hospital.

Newborn Child

A newborn child will be insured from the date of birth. A newly born adopted child will be insured from the moment of birth, if:

1. the child is adopted by the Person; or

2. the Person takes physical custody of the child upon such child's release from the Hospital, and:

   a. the Person files a petition pursuant to the date of adoptive placement to Section 115-c of the Domestic Relations Law within 30 days of birth;

   b. no notice of revocation to the adoption has been filed pursuant to Section 115-b of the Domestic Relations Law; and

   c. consent to the adoption has not been revoked.

Benefits will be paid for Treatment of Injury or Illness. Covered expenses will include the necessary care of medically diagnosed congenital defects and birth abnormalities, including premature birth, except in cases of adoption, coverage for the initial Hospital stay will not be required where a natural parent has insurance coverage available for the child's care.

When a Dependent's Insurance Terminates

Unless otherwise stated, a Dependent's insurance under this Policy will terminate upon the earliest of:

1. the date this Policy terminates;

2. the date the Person's insurance terminates;

3. the date this Policy is amended to terminate insurance for the class to which the Dependent belongs;

4. the date the Dependent is no longer eligible as provided under *Eligible Dependents*, in this Section; or

5. the date the Dependent enters into full-time active duty with the Armed Forces of any country.

Upon termination, a Dependent may be entitled to pay the premium and continue his or her insurance under this Policy. Refer to *Continuation of Coverage Upon Termination* in this Section.

SECTION 4 - CONTINUATION OF COVERAGE UPON TERMINATION AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

(This provision applies to Medical Benefits)

The following continuation rights are designed to comply with both:

1. the state's requirements for continuation upon a Person's involuntary termination, upon a Dependent's ineligibility as a Dependent under the terms of this Policy or upon the Person's Medicare eligibility; and

2. the requirements for continuation as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If a Covered Person's insurance would otherwise terminate due to a qualifying event, he or she may elect to pay the premium and continue his or her Medical Expense Benefits under this Policy.

The insurance that is continued will be the same insurance that would apply to a Covered Person who is in the same class and not on continuation, subject to the terms and conditions for continuation described in this provision.

The Policyholder may designate the Company or another entity to administer this provision. A Covered Person will be advised who to contact in the event he or she qualifies for continuation.

Continuation Rights for Persons and Dependents Upon a Person's Qualifying Event

If a Person's insurance terminates due to a qualifying event, he or she is entitled to continue insurance under this Policy for up to 18 months, including coverage for his or her eligible Dependents, provided the Person is not entitled to benefits under Medicare. With respect to a Person, a "qualifying event" occurs when insurance under this Policy would terminate due to the following:

1. termination of employment, other than for gross misconduct;

2. termination of membership in an Eligible Class for coverage under this Policy; or

3. a reduction in the hours the Person works; or

4. termination or substantial reduction of a retired Person's coverage within one year before or after the Employer files bankruptcy proceedings under Title 11 of the United States Bankruptcy Code.

Each of the Person's eligible Dependents has the right to elect or decline continued coverage as a result of the Person's qualifying event.

Extension For Person or Dependent Due to Disability

If Social Security, under its rules, determines that a Person or Dependent was disabled at the time of the Person's qualifying event, the maximum period of continuation for such a qualifying event may be extended from 18 to 29 months. The extended continuation period is only available to a Person or Dependent who meets the following:

1. he or she was disabled on the date of the Person's qualifying event; and

2. notice is given to the Policyholder or its designee of Social Security's determination:

    a. within 60 days of the determination; and

    b. before the initial 18 month continuation period ends.

In no event will the continuation period be extended for disability beyond the earliest of:

1. the last day of the month that begins more than 31 days after Social Security determines that the Person or Dependent is no longer disabled. The Person or Dependent must notify the Policyholder or its designee within 31 days of the date of such a Social Security determination;

2. the date continued insurance would end for any reason other than the end of the 18 month continuation period; or

3. the end of 29 months following the date of the Person's qualifying event.

Dependent Continuation Period Upon Person's Entitlement to Medicare

If the Person's qualifying event occurred after the date the Person became entitled to Medicare benefits, the maximum continuation period with respect to an eligible Dependent will be the later of:

1. the end of the 18 month continuation period; or

2. the end of a 36 month period from the date the Person became entitled to Medicare benefits.

Continuation Rights for Dependents Upon a Dependent's Qualifying Event

If a Dependent's insurance terminates due to a qualifying event, such Dependent is entitled to elect to continue insurance under this Policy for up to 36 months, provided the Dependent is not entitled to benefits under Medicare. With respect to a Dependent, a "qualifying event" occurs when insurance under this Policy would terminate due to:

1. the Person's death;

2. the Person and Dependent spouse becoming divorced or legally separated;

3. the Person's entitlement to benefits under Medicare; or

4. a child no longer qualifying as a Dependent under this Policy as determined under Section 3B, *Dependents To Be Insured.*

However, if a Dependent is already on continuation of insurance as a result of the Person's qualifying event, and a second qualifying event occurs with respect to the Dependent, such Dependent may continue insurance up to a maximum of 36 months from the date of the Person's qualifying event.

Notice Requirements

By Policyholder

The Policyholder or its designee must notify each Person and Dependent of his or her right to continue insurance under this Policy. Such notice must be given within 14 days after the Policyholder or its designee receives notice, or becomes aware, that a Person or Dependent is entitled to continue insurance under this provision. Unless the Company has been designated by the Policyholder to administer these requirements, the Company shall have no obligation to provide this Notice.

By the Person or Dependent

The Person or Dependent must notify the Policyholder of the following Dependent qualifying events, within 60 days after the date it occurs, in order to be eligible for continued insurance:

1. divorce or legal separation; or

2. a dependent child no longer qualifying as a Dependent under this Policy.

A written request for continuation must be made within 60 days of the later of:

1. the date of the qualifying event; or

2. the date on which the Policyholder or its designee gave the Person or Dependent notice of this right to continue insurance.

Premium Payment

The monthly premium rate for continued insurance will be stated on the Notice.

The initial premium must be paid to the Policyholder or its designee within 45 days (60 days for New York Residents) of the date the election to continue insurance is made. Each subsequent monthly premium must be paid by the Person or Dependent to the Policyholder or its designee within 30 days of the premium due date.

Termination of Continued Insurance

Insurance will be continued on a month-to-month basis until the earliest of:

1. the end of the maximum continuation period stated above for a qualifying event, including an extension for disability;

2. the date the Person or Dependent becomes entitled to benefits under Medicare;

3. the last day of the month for which premiums were paid to the Company in the event of non-payment of premium;

4. the date the Person or Dependent first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise) which does not exclude or limit any preexisting condition of the Person or Dependent; or

5. the date this Policy terminates.

Conversion Rights

At the end of the continuation period, a Person or Dependent will be entitled to the same conversion rights that applied to such Person or Dependent on the date of his or her qualifying event.

SECTION 5 - PREFERRED PROVIDER ORGANIZATION (PPO) OPTION

The Company has contracted with one or more PPO Corporations to make available a group of Preferred Providers to provide health care services to the Person and his or her eligible Dependents in the network area.

Definitions

A "Preferred Provider" means a provider of health care services that holds a valid contract with the PPO Corporation to provide health care services in the network area. A Preferred Provider may be a Doctor or other facility of health care services. The Company will maintain a current list of the Preferred Providers in the network area.

A "Non-Preferred Provider" means a provider of health care services that is not a Preferred Provider, but whose charges are covered expenses under this Policy.

Freedom of Choice of Provider

A Covered Person will be given a current list of the Preferred Providers in his or her network area, which will be updated at least annually. A Covered Person is not required to go to a Preferred Provider. At the time of service, the Covered Person may obtain care or Treatment from a Preferred Provider or a Non-Preferred Provider. However, to maximize the benefit reimbursement level under this Policy, a Preferred Provider must be used.

Benefits of Using a PPO Provider

If a Covered Person uses the services of a Preferred Provider, benefits will generally be reimbursed at a higher level, as shown on the *Schedule of Benefits*.

Note: A Covered Person must present his or her PPO Identification Card to the Preferred Provider at each visit to assure that the Preferred Provider is aware that the individual is covered under this provision.

SECTION 6 - COMPREHENSIVE HEALTH BENEFIT

Benefits will be paid for Covered Medical Expenses incurred by a Covered Person while insured for this benefit as the result of an Injury or Illness, except as provided under the *Extension of Benefits* provision in this Section. Payment is subject to all the terms and conditions of this Policy.

Determination of Benefit

All Covered Medical Expenses are subject to the Deductible, Copayment, Coinsurance Rate and Lifetime Maximum Benefit as shown on the *Schedule of Benefits*. Any applicable Deductible will be subtracted from Covered Medical Expenses before a benefit is paid. The benefit to be paid is then determined by multiplying the Coinsurance Rate by the remaining amount of Covered Medical Expenses.

Deductible

"Deductible" means the amount of Covered Medical Expenses incurred for which no benefit is paid under this Policy. The Deductible will apply each calendar year to each Covered Person, except as provided under the *Three Month Carry-Over* or *Family Deductible* provisions below.

Three Month Carry-Over

Covered Medical Expenses incurred during the last 3 months of a calendar year, which are applied to that year's Deductible, will also be applied to the next year's Deductible.

Family Limit

On the date that members of a Family have collectively satisfied the dollar amount shown in the *Schedule of Benefits* during a calendar year, no further Deductible will apply to that Family for charges incurred during the rest of that calendar year. "Family" means an insured Person, and the individuals insured as his or her Dependents under this Policy.

Copayment

The Copayment shown on the *Schedule of Benefits* is the amount of money that each Covered Person must pay for certain Covered Medical Expenses under the Preferred Provider option.

Coinsurance Rate

The Coinsurance Rate shown on the *Schedule of Benefits* is the percent of Covered Medical Expenses payable under this Policy.

Coinsurance Limit

When a Covered Person has incurred Covered Medical Expenses which equal the out-of-pocket amount, on the *Schedule of Benefits*, in a calendar year, the Coinsurance Rate will be increased to 100% for that Covered Person for the remainder of that calendar year.

Lifetime Maximum Benefit

This Comprehensive Health Benefit only provides reimbursement for expenses incurred while an individual is insured under this benefit, except as provided under the Extension of Benefits for Total Disability provision.

The Lifetime Maximum Benefit shown on the *Schedule of Benefits* will apply to each Covered Person while he or she is insured under this Policy at any time. If there is a break in insurance, only the portion of any Lifetime Maximum Benefit remaining on the date of termination of insurance will be reinstated when insurance resumes.

Covered Medical Expenses

Covered Medical Expenses are charges incurred by a Covered Person for the following expenses, except as excluded under *Exclusions* in this benefit:

1. charges made by a Doctor, practicing with the scope of his or her license, for Treatment, surgery, and medical care;

2. charges made by the following licensed or certified health care providers for medical care within the scope of their license or certificate:

   a. certified nurse practitioner;

   b. licensed registered professional nurse;

   c. licensed or certified midwife, or nurse midwife;

3. charges made by a licensed or certified physical therapist or occupational therapist for medical care;

4. charges made by a Private Duty Nurse, if such service is prescribed by the attending Doctor, and such service excludes all domestic activities;

5. charges made by an Ambulatory Surgical Center;

6. charges made by a facility, or portion of a facility, which is licensed and operating as an acute care or general Hospital. Covered Medical Expenses shall include charges for Treatment as an Inpatient or Outpatient. Inpatient daily room and board charges, consisting of bed and board, including general nursing care and special diets, are limited to:

   a. the Hospital's average semiprivate room rate for other than intensive, coronary or similar care;

   b. the Hospital's average semiprivate room rate for the area, if the Hospital consists of only private rooms, 80% of its minimum daily rate for private accommodations will be considered its regular daily semiprivate room rate;

c. the Hospital's average private room rate if the care requires a private room; or

d. the Reasonable and Customary charge for intensive, coronary, or other similar care;

7. charges made by a facility licensed by the state to provide Emergency Medical Treatment, including surgery, on an Inpatient or Outpatient basis. "Emergency Medical Treatment" means the Treatment of a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonably result in:

   a. placing the Covered Person's life in danger; or

   b. causing serious impairment of bodily functions.

   Coverage will be provided if Treatment is provided in a facility licensed by the state to provide Emergency Medical Treatment, including surgery, on an Inpatient or Outpatient basis. Benefits will be paid as shown on the *Schedule of Benefits*;

8. charges by a licensed or certified speech therapist, but only for care for restoring speech loss or correction of:

   a. an impairment due to or related to an Injury or Illness, if speech was normal before such Injury or Illness and such Injury or Illness is not a functional nervous disorder; or

   b. a congenital malformation for which corrective surgery has been performed;

9. charges incurred for dental care, but only if such charge is for:

   a. Treatment of a disease or Injury of any of the following: jaw; facial bones; teeth or gums; if the service is (i) performed by a Doctor; (ii) not for periodontal disease; and (iii) not performed in connection with the extraction of teeth for the fitting of dentures;

   b. removal of a cyst, leukoplakia or malignant tissue;

   c. correction of a harelip, cleft palate, or protruding mandible;

   d. freeing of a muscle attachment; or

   e. Treatment of a natural tooth injured in an accident, if (i) the accident occurs and the Treatment is rendered while the patient is insured under this Policy; (ii) the Treatment is begun within 90 days after the accident; and (iii) the charges for such Treatment are incurred within one year after such accident;

10. charges incurred for foot care, but only if such charge is for:

    a. an open cutting operation of metatarsalgia or bunion;

b. a partial or complete removal of a nail root;

c. medical care of the feet, if it is not for: (i) Treatment of weak, strained or flat feet; or instability or imbalance of the feet; (ii) Treatment of any metatarsalgia or bunion; or (iii) orthopedic shoes and any other supportive device; or

d. other Treatment of the feet, if it is not a cutting, removal or other Treatment of a: corn; callus; or toenail; unless such Treatment is needed because of diabetes or other similar disease;

11. charges made by a Doctor, certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian for diabetes self-management education and diabetic diet education which has been prescribed by a Doctor;

12. charges made by a Board Certified Doctor's opinion evaluating the need for non-emergency surgery. If this second opinion does not confirm the need for surgery, charges for a third opinion will also be covered;

13. charges for transportation of a Covered Person by a local ambulance service to the nearest Hospital for the Treatment of an Injury or Illness. Local ambulance service does not include a service by a railroad, ship, helicopter, airline or other common carrier;

14. charges for diagnostic x-ray and laboratory services;

15. charges for x-ray, radium or radioactive isotope therapy; charges for cancer chemotherapy;

16. charges for the administration or dialysis of blood or blood components. Charges for the cost of whole blood or blood components, if the blood is not replaced;

17. charges for anesthetics and their administration under the direction of a Doctor;

18. charges for drugs and medicines, which require the written prescription of a Doctor. The Covered Person must pay the full discounted amount for the prescription, then submit a claim to Health Benefits System for reimbursement;

19. charges for oxygen and the rental of equipment for its administration;

20. charges for the rental of Durable Medical Equipment, but not to exceed the purchase price. At the Company's option, and on a basis determined by the Company, purchase may be made. "Durable Medical Equipment" means equipment or FDA approved medical devices that are Medically Necessary to aid in a Covered Person's recovery, mobility and/or the support of life. Such Durable Medical Equipment must:

a. be prescribed by the attending Doctor;

b. be designed for prolonged use;

c. not be primarily used for non-medical purposes; and

d. not be specifically excluded by this Policy;

21. charges for the purchase of casts, splints, trusses, braces, or crutches;

22. charges for non-dental prosthetic devices such as artificial limbs or eyes, or other prosthetic appliances. Replacement of such devices will be covered only if required by a change in the Covered Person's physical structure;

23. charges for expenses for maternity care will be provided on the same basis as any other Illness, if the pregnancy commenced while the Covered Person was covered under this Policy. However, coverage for Covered Hospital expenses will be paid up to 4 days of Hospital confinement;

24. charges incurred for diagnosis and Treatment of correctable medical conditions which would otherwise be covered under this Policy solely because the medical condition results in infertility;

25. charges incurred for the Treatment of temporomandibular joint dysfunction syndrome (TMJ), or any other Treatment of the face, neck, or head are covered on the same basis as any other Treatment of the skeletal system, if the procedure is Medically Necessary to treat a condition caused by congenital deformity, Injury or Illness. However, charges for intraoral prosthetic devices are excluded;

26. charges incurred for mammography screening for a Covered Person who does not have symptoms of cancer will be considered Medically Necessary. Benefits will be paid for one or more examinations, per calendar year;

27. charges incurred for a cervical cytology screening (pap smear) for a woman who does not have symptoms of cancer will be considered Medically Necessary. Benefits will be paid for one or more pap smears, per calendar year;

28. charges incurred for prenatal care and postnatal care Treatment;

29. charges incurred for preventive and primary care services for a Dependent child of a Person from the date of birth through the attainment of 19 years of age. Such coverage will consist of the following services:

a. an initial Hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric Doctors designated by the Commissioner of Health;

b. such coverage will be provided only to the extent that such services are provided by or under the supervision of:

(1) a Doctor, or in a Doctor's office; or

(2) an other professional licensed under Article 139 of Education Law whose scope of practice includes the authority to provide the specified services provided in a Hospital, or in such professional's office;

c. at each visit, services in accordance with the prevailing clinical standards of such designated association, including:

(1) a medical history;
(2) a complete physical examination;
(3) developmental assessment;
(4) anticipatory guidance;
(5) appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory; and

d. necessary immunizations as determined by the Superintendent in consultation with the Commissioner of Health consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type b and hepatitis b which meet the standards approved by the United States Public Health Service for such biological products.

Coverage will not be subject to the calendar year deductible or Coinsurance Limit shown on the *Schedule of Benefits*;

30. charges for Home Health Care visits, by a Hospital or Home Health Agency, if the visits follow a Hospital or Nursing Home stay, and: (i) the Covered Person's Doctor certifies that home health care is necessary to treat the Injury or Illness which caused the stay; and (ii) the visits begin within 14 days after such stay. However, the 14-day requirement will be waived if the Covered Person's Doctor certifies that home health care is in lieu of a stay. Up to four consecutive hours of home health care services rendered by a provider of home health care will be considered one visit.

"Home Health Agency" means an agency: (a) primarily engaged in providing home nursing care and other therapeutic services for persons who suffer from an Injury or Illness; and (b) which either qualifies for payment under Medicare or is established and operated under applicable state law;

31. charges incurred for Hospice care as Medically Necessary expenses, as follows:

a. an Inpatient charge made by a Hospice during a benefit period of 31 days and each additional 31-day period which: (i) a Terminally Ill Patient's Doctor certifies is necessary and (ii) the Company approves;

b. by a Hospital or Home Health Agency for home health care furnished to a Terminally Ill Patient under the direction of a Hospice, including Custodial Care if it is given during a regular visit by a Private Duty Nurse or a home health aide;

c. by a Private Duty Nurse, if the Doctor or the Hospice certifies that nursing care is necessary;

d. for the following medical supplies: (i) drugs and medicines prescribed or ordered by a Terminally Ill Patient's Doctor for symptom control, and for their administration; or (ii) the rental of durable equipment of a medical or surgical nature which is used solely for treating a Terminally Ill Patient's Injury or Illness; or

e. for the following other Hospice care services:

(1) by a licensed social worker, including: (i) an evaluation of the social, psychological and family problems related to the Terminally Ill Patient's Injury or Illness; and/or (ii) the development of a plan to assist in resolving these problems, using community resources when possible;

(2) for professional services for rendering emotional support to the Terminally Ill Patient, including help to: relieve stress; cope with impending loss; complete unfinished business; and/or maintain the patient in the most appropriate environment;

(3) incurred for special services rendered in connection with the Terminally Ill Patient's Injury or Illness, including transportation between the Hospice and the patient's home and special dietary services; or

(4) for professional services for family counseling after the death of the Terminally Ill Patient.

"Hospice" means a facility providing a coordinated program of home and Inpatient care for Terminally Ill Patient. To qualify, the Hospice must meet the standards of the National Hospice Organization and the applicable state licensing requirements.

"Terminally Ill Patient" means a Covered Person who has a life expectancy of six months or less. This must be certified in writing by the Covered Person's Doctor. If the Covered Person lives more than six months, the Company may still consider such Covered Person a Terminally Ill Patient, if his or her Doctor again certifies a life expectancy of six months or less;

32. charges incurred for Treatment of Mental Illness will be paid on the same basis as any other Illness, subject to the limitations shown on the *Schedule of Benefits*.

Inpatient Treatment may be provided by: (i) a Doctor; (ii) a licensed psychiatrist or licensed psychologist; or (iii) a Certified Social Worker.

Outpatient Treatment may be provided by: (i) a Psychiatric Residential Treatment Center; (ii) a licensed psychiatrist or psychologist; (iii) a professional corporation; (iv) a Certified Social Worker.

Emergency Outpatient Treatment will be covered if such Treatment is certified by a licensed mental health care provider whose services are covered under this Policy that a visit is the result of a psychiatric emergency.

Benefits incurred for Emergency Outpatient Treatment services will reduce the benefits payable for Inpatient and Outpatient Treatment, as shown on the *Schedule of Benefits*.

"Mental Illness" means any condition, regardless of the underlying cause of such condition, which is classified as a mental, nervous or emotional disorder in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. Mental Illness does not include mental retardation.

"Psychiatric Residential Treatment Center" means a facility accredited by the Joint Commission of Hospitals for the therapeutic care and Treatment of Mental Illness;

33. charges incurred for Inpatient and Outpatient Treatment of Chemical Dependency will be paid on the same basis as any other Illness, subject to the limitations shown on the *Schedule of Benefits*.

Expenses incurred by a Chemical Dependency Treatment Facility for Treatment of Chemical Dependency will be a Covered Medical Expense. Benefits will be payable for services provided in the residential Treatment of Chemical Dependency for:

a. room and board furnished to a Covered Person who is treated on a resident basis;

b. medical, nursing and dietary services;

c. patient diagnostic assessment and Treatment;

d. individual, group and family counseling; and

e. educational support services.

"Chemical Dependency" means, the abuse of or psychological or physical dependency on or addiction to alcohol or a controlled substance. For purposes of this definition, "controlled substance" means a toxic inhalant, a volatile chemical, abusable glue or aerosol paint, or a substance designated as or considered a controlled substance under applicable federal, state or local authority.

"Chemical Dependency Treatment Facility" means, a Treatment center which provides coordinated Inpatient and Outpatient Treatment of Chemical Dependency by trained medical personnel and counselors pursuant to a written Treatment plan approved and monitored by a Doctor. The facility must also be: (i) affiliated with a Hospital under a contractual agreement with an established system for patient referral; (ii) accredited as such a facility by the Joint Commission on Accreditation of Hospitals; (iii) licensed, certified, or approved as a Chemical Dependency Treatment program or center by any federal, state or municipal agency having legal authority to so license, certify, or approve;

34. charges for Cosmetic surgery and the related medical care, but only if the charge is for:

a. an Injury sustained by a Covered Person in an accident, if: (i) the accident occurs and the Cosmetic surgery is performed, whether or not the surgery is performed for emotional or psychiatric reasons, while the patient is insured under this Policy; and (ii) the Cosmetic surgery is begun within 90 days after the accident; or

b. a congenital anomaly of a child if the child became insured under this Policy at birth.

Any other Treatment, including hair restoration, if the primary purpose of the Treatment is to improve appearance is not covered;

35. charges incurred for correction by manual or mechanical means of structural imbalance, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in, the vertebral column. Benefits will be paid for spinal manipulation as shown on the *Schedule of Benefits*;

36. charges incurred for routine physical exams will be considered Medically Necessary and will be paid as shown on the *Schedule of Benefits*;

37. charges incurred for immunizations will be considered Medically Necessary and will be paid as shown on the *Schedule of Benefits*;

38. charges incurred for a Secondary Surgical Procedure. Benefits will be paid as shown on the *Schedule of Benefits*.

"Secondary Surgical Procedure" means a surgical procedure(s) performed during the same operative session as primary procedure, if:

a. the secondary procedure is to correct a separate pathological condition;

b. the pathological condition would have required surgical intervention had an incision not already been present; and

c. the degree of difficulty, operating time and risk were significantly increased by the secondary procedure; and

39. charges for speech-language or audiology services provided by, and within the lawful scope of practice of:

a. a licensed speech-language pathologist; or

b. a licensed audiologist.

Coverage will include **one** test or evaluation during the calendar year, if such test or evaluation is:

a. ordered by a Doctor as Medically Necessary; and

b. provided:

(1) in a Hospital;

(2) a Doctor's office; or

(3) in a Covered Person's home when such service is provided as part of a home health care agency's services.

However, no coverage will be provided for any test, evaluation, or diagnosis required by a medical order or similar or related service of a Doctor that have already been provided by or through a Doctor within 12 months of such referral or order from the Doctor.

Preexisting Conditions Limitation

No benefits are payable under this Policy for a Preexisting Condition, or for charges relating to a Preexisting Condition.

"Preexisting Condition" means an Injury or Illness or any condition related to such Injury or Illness for which an individual consults a Doctor, receives medical services or supplies or takes any medication during the 12-month period immediately before the Covered Person's effective date of coverage under this Policy, if such Injury or Illness or condition is not fully disclosed when a request for initial insurance is made under this Policy. Preexisting Condition does not include any such Injury or Illness or condition after such individual has been has insured under this Policy for 9 months.

Exception

The Preexisting Condition Limitation will not apply to:

1. congenital anomalies conditions of a Dependent chid; or

2. for Covered Persons who were covered under the Policyholder's prior group health plan which this Policy replaced, coverage under this Policy will be provided without evidence of insurability and benefits subject to this Preexisting Condition Limitation will be the lesser of:

   a. the benefits payable under this Policy without application of the Preexisting Condition Limitation; or

   b. the benefits that would have been payable under the prior group plan, until the Preexisting Condition Limitation no longer applied.

Exclusions

The following charges are not Covered Medical Expenses:

1. any charges which are not listed as a Covered Medical Expense;

2. charges incurred for Treatment of the teeth or gums, or alveolar processes, except as specifically listed as a Covered Medical Expense. However, charges incurred for the repair or replacement of natural teeth required as the result of and within one year of an accidental Injury, (and not as the result of biting or chewing) will be a Covered Medical Expense;

3. charges incurred for the purchase or fitting of hearing aids;

4. any portion of a charge which is in excess of the Reasonable and Customary charge for the Treatment;

5. any charge for Treatment that the Company determines is not Medically Necessary. To determine this, the Company may rely upon the advice of its medical review department and/or an independent medical reviewer and other medical experts. This provision shall not exclude any charges for a covered Treatment which specifically states that such Treatment will be considered Medically Necessary under this Policy;

6. charges incurred for a Treatment that is not generally accepted by the medical profession, or is listed as experimental, under investigation, or limited to research;

7. charges incurred for surgery to the eye to correct a refractive error, such as radial keratotomy; charges incurred for the examination for the prescription or fitting, and for the purchase or fitting of eyeglasses or contact lens. However, charges incurred for a contact lens or eyeglasses and frames required immediately following and as a result of cataract surgery will be a Covered Medical Expense;

8. charges incurred in connection with Treatment that is Cosmetic, other than:

   a. reconstructive surgery to restore tissue damaged by Injury or Illness when such Treatment is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; or

   b. Treatment of a child from birth to correct a congenital disease or anomaly, including an oral defect;

9. charges incurred in connection with a change in gender;

10. charges incurred for the purchase or fitting of contraceptive devices; charges incurred for a voluntary surgical sterilization, or its reversal; or charges incurred for drugs or surgery which do not correct the condition of infertility. These include but are not limited to: artificial insemination; in vitro fertilization; hormone therapy; embryo transfer; gamete intra-fallopian transfer ("GIFT");

11. charges incurred for an elective abortion, except where the life of the mother is in danger if the procedure is not performed;

12. charges made by a Covered Person or his or her parents; guardian; spouse; brother; sister; natural, step, adopted or foster child; grandparent; in-law or a person residing in the Covered Person's household;

13. charges incurred for Custodial Care, or rest cures. "Custodial Care" means services to help in transferring, eating, dressing, bathing, toileting, and other such related activities;

14. charges incurred for transportation, unless specifically provided as a covered charge under this Policy;

15. charges incurred for any type of Treatment used for developmental purposes. This does not exclude Medically Necessary Treatment ordered by a Doctor to restore a functional loss that was the direct result of an Injury or Illness;

16. charges which a Covered Person is not legally obligated to pay for; or Treatment which he or she obtains, or is entitled to obtain, under any plan or program without charge, except Medicaid. This will include charges for Treatment which is provided or paid for by the federal government at a Veteran's Administration facility for:

    a. an Injury or Illness related to the Covered Person's military service; or

    b. the Person, or his or her Dependents, if the Person retired from the armed services;

17. charges incurred as a result of war or an act of war, whether declared or not, or any related act; charges incurred as the result of participation in a riot or insurrection; or charges incurred as the result of the Covered Person's participation in a felony;

18. charges incurred as a result of:

    a. an Injury which arises out of or in the course of any employment with any employer; or

    b. an Illness;

    for which the Covered Person:

    a. is entitled to benefits under any workers' compensation law or occupational disease law; or

    b. receives any settlement under any workers' compensation or occupational disease plan;

19. charges incurred for any Injury sustained or Illness contracted in consequence of the Covered Person's being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor;

20. charges incurred for normal nursery care of a newborn dependent child, unless such charge is incurred for the infant's Injury or Illness and as otherwise specified herein;

21. charges incurred for nonprescription medicines, oral contraceptives, vitamins, nutrients and food supplements, even if prescribed or administered by a Doctor;

22. charges made by a Nursing Home;

23. charges incurred for care relating to gastric by-pass, intestinal by-pass, gastroplasty, liposuction or relating to any other Treatment for obesity or weight control, unless such charge is related to the correction or improvement of morbid obesity;

24. charges incurred for routine health examinations or immunizations, except as otherwise provided herein;

25. charges incurred for recreational or leisure therapy;

26. charges for dental care or Treatment, or dental x-rays, except as otherwise provided herein;

27. charges incurred for foot care, except as otherwise provided herein;

28. charges for services or supplies for the Treatment of Injuries or accidents suffered at any pari-mutual track which does not have on-track accident insurance in effect either inside or outside the United States as stipulated by agreement between the Policyholder and the Thoroughbred Racing Association.

    Any charge attributable to an Injury as defined in this Policy issued to the Policyholder by the Company, as subsequently amended or changed (this "Policy") to the extent such charges are payable under this Policy, would have been payable under this Policy if it were in effect at the time of such Injury; or is payable under any Accident or Workers' Compensation policy providing benefits greater than those provided under this Policy;

29. charges incurred for speech therapy, except as otherwise provided herein;

30. charges made by a Hospital on:

    a. Friday and Saturday, if the Covered Person is admitted to the Hospital on such Friday; or

    b. Saturday, if the Covered Person is admitted to a Hospital on such Saturday;

    unless the admission is for Emergency Medical Treatment or if surgery is performed within 24 hours after such admission; or

31. charges incurred for any loss that is caused directly or indirectly, or in whole or in part, by suicide, attempted suicide or intentionally self-inflicted Injury.

SECTION 7 - EXTENSION OF BENEFITS

For Total Disability

If a Covered Person is Totally Disabled on the date his or her Comprehensive Health Benefit terminates because the Person's active employment terminates, benefits will be extended solely for Covered Medical Expenses incurred by that Covered Person as the direct result of the Total Disability. Coverage will be extended until the earliest of the following:

1. the date the individual ceases to be Totally Disabled;

2. the date the maximum benefit under this Policy has been paid; or

3. the end of a 12-month period from the date the individual's insurance terminated under this Policy;

unless coverage is provided for the Total Disability under another group health plan.

Extension of Benefits for Pregnancy

Coverage will be provided under this extension of benefit provision for a Covered Person who incurs Covered Medical Expenses as a result of pregnancy, childbirth or related medical conditions if such charges are:

1. incurred after the Covered Person's coverage under this Policy terminates; and

2. the result of a pregnancy which commenced while the Covered Person's coverage under this Policy was in effect.

As used in this provision, "Totally Disabled" means a state of incapacity due to an Injury or Illness, and:

1. with respect to a Person, the Person's inability to work at his or her normal job; or

2. with respect to a Dependent, the Dependent's inability, due solely to Illness or Injury, to engage in all of the normal activities of an individual of like age and sex who is in good health.

NOTE: If an individual is eligible to convert his or her Medical Expense Benefits as described in the next provision, he or she must do so within 31 days (45 days for New York residents) from the date such coverage terminates under this Policy. This Extension of Benefits for Total Disability provision does not extend the period of time during which an individual is insured under this Policy.

SECTION 8 - CONVERSION RIGHTS FOR MEDICAL EXPENSE BENEFITS

If a Covered Person's Medical Expense Benefits terminate, he or she may be eligible to convert such insurance to a conversion policy then available through the Company, without evidence of insurability.

The benefits under the conversion policy may not be the same as the benefits of this Policy. Such conversion policy will not include all of the benefits, nor the same level of benefits as this Policy. To obtain details of the benefit plans available for conversion, and the cost, the Covered Person must send a written request for information to the Company. A form to request information for conversion is available through the Company and/or the Policyholder.

Who is Eligible to Convert?

The following Covered Persons who:

1. have been insured under this Policy, or the prior plan replaced by this Policy, for at least 3 months immediately prior to the date his or her insurance terminated;

2. are not entitled to similar medical expense coverage under any other group, whether on an insured or uninsured basis, or government plan, including Medicare; and

3. are not entitled to similar medical expense coverage pursuant to any law;

are eligible for conversion insurance:

1. a Person whose insurance terminated:

    a. for any reason; or

    b. due to termination of this Policy, for any reason unless the Policyholder replaces this Policy with similar and continuous coverage for the same group whether insured or self-insured; or

2. a Dependent spouse whose insurance terminated:

    a. because the Person died; or

    b. because of divorce or annulment of marriage from the Person; or

3. a child who no longer qualifies as an *Eligible Dependent* under Section 3B, *Dependents To Be Insured*.

The individual who is converting may insure his or her Eligible Dependents whose insurance terminated under this Policy at the same time.

Application and Effective Date

In order to be eligible to convert, the individual must apply and pay the first premium due within 31 days from the date his or her Medical Expense Benefits terminated under this Policy.

For New York Residents: In order to be eligible to convert, the individual must apply and pay the first quarterly premium, or a less frequent mode of payment if elected by the Covered Person, due within 45 days from the date his or her Medical Expense Benefits terminated under this Policy.

The effective date of the conversion insurance will be the day after the date insurance terminated under this Policy.

Premium

The initial premium for the conversion insurance will be based on:

1. the form and amount of conversion insurance the individual elects; and
2. the premium rates then in effect for that class of insurance; and
3. the ages, on the effective date, of each individual to be insured; and
4. the class of risk of each individual to be insured.

For New York Residents: However, a Person who has attained age 60 and have been insured under this Policy for at least 2 years immediately preceding the date the Person first became entitled to a converted policy will be entitled to obtain the converted policy for a premium computed at a rate which in any Policy Year will not exceed 120% of a net level premium approved by the Superintendent upon becoming entitled to this conversion privilege.

Required Notice

The Policyholder will give the Person, or mail to the Person's last known address, a written notice of the conversion privilege and its duration within 15 days before or after the date of termination of coverage under this Policy. However, if such notice is given more than 15 days, but less than 90 days, after the date of termination of coverage under this Policy, the time allowed for the exercise of such conversion privilege will be extended for 31 days (45 days for New York residents) after giving such notice. If such notice is not given within 90 days after the termination of coverage under this Policy, the time allowed for the exercise of such conversion privilege will expire at the end of such 90 days.

This provision does not extend insurance beyond the date such insurance terminates in accordance with the terms and conditions of this Policy.

SECTION 9 - COORDINATION OF BENEFITS (COB)

Benefits Subject to COB

All medical benefits under this Policy are subject to this provision.

When Does COB Apply?

Coordination of Benefits (COB) will apply when a Covered Person is covered for medical benefits under more than one Plan. "Plan" is defined below under Plans Considered for COB.

If this COB provision applies, the Order of Benefit Determination Rules below should be looked at first. Those rules determine whether this Policy is a Primary Plan or a Secondary Plan. A "Primary Plan" means the Plan which pays benefits or provides services first under the rules. A "Secondary Plan" is any Plan that is not a Primary Plan. When there are more than two Plans covering the Covered Person, this Policy may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

If this Policy is:

1. a Primary Plan, COB will not apply and benefits will not be reduced; or

2. a Secondary Plan, COB will apply, and benefits may be reduced so that the total payment from all Plans will not exceed 100% of total Allowable Expenses. This reduction is described under Effect on Benefits below.

Plans Considered for COB

"Plan" is any of the following which provides benefits or services for, or because of, medical, care or Treatment:

1. group, remittance subscriber, blanket or franchise insurance or other group-type coverage, whether insured or uninsured. This includes HMOs and other prepayment, group practice or individual practice coverage;

2. union welfare plans, employer organization plans, or labor-management trusteed plans;

3. the medical benefits coverage provided in group and individual mandatory "no-fault" and traditional mandatory automobile "fault" type policies;

4. coverage under Medicare or other governmental plan for medical benefits only, or coverage required or provided by law. This does not include benefits payable under any state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or any plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Each contract or other arrangement for coverage under 1. through 4. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Plan" will not include:

1. individual or family:

   a. insurance policies;

   b. direct-payment subscriber contracts;

   c. coverage through health maintenance organizations (HMOs); or

   d. coverage under other prepayment, group practice and individual practice plans.

2. group hospital indemnity benefit amounts which are less than $150 per day; or

3. school accident-type coverage.

Order Of Benefit Determination Rules

General

When there is a basis for a claim under this Policy and another Plan, this Policy is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Policy; and

2. both those rules and this Policy's COB Rules require that this Policy's benefits be determined before those of the other Plan.

Rules

This Policy determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the individual as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the individual as a dependent.

2. Dependent Child/Parents not Separated or Divorced. Except as stated in Rule 3., when this Policy and another Plan cover the same child as a dependent of different individuals, called "parents":

   a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

b. if both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have this "birthday rule", but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced. If two or more Plans cover a child as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. first, the Plan of the parent with custody of the child;

b. then, the Plan of the spouse of the parent with the custody of the child; and

c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has the actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers the individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers the individual as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule 4. is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered the employee, member or subscriber for the shorter term.

Effect on Benefits

COB applies to this Policy when, in accordance with the Order of Benefit Determination Rules, this Policy is a Secondary Plan as to one or more other Plans. In that event the benefits of this Policy may be reduced under this COB provision. Such other Plan or Plans are referred to as "the other Plans" immediately below.

Reduction in this Policy's Benefits

The benefits of this Policy will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expense under this Policy in the absence of this COB provision; and

2. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Policy will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. As each claim is submitted, the Secondary Plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

When the benefits of this Policy are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Policy.

"Allowable Expense" means a Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the Covered Person for whom the claim is made, unless the law requires otherwise.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual has no coverage under this Policy, or any part of a year before the date this COB provision or a similar provision takes effect.

As each claim is submitted, each Plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. The Company need not tell, or get the consent of, any individual to do this. Each Covered Person claiming benefits under this Policy must give the Company any facts it needs to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Policy. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Policy. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the individuals it has paid or for whom it has paid;

2. insurance companies; or

3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

However, a Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. No cash reimbursement will be made for the value of services provided by a Plan which provides benefits in the form of services.

SECTION 10 - COORDINATION OF BENEFITS AND MEDICARE

Medicare Benefits at Age 65

If a Covered Person is entitled to benefits under Medicare because he or she is age 65, the following rules will determine which Plan is primary under the Coordination of Benefits (COB) provision.

For Active Persons and Their Dependents

This Policy will be the Primary Plan to Medicare for a Covered Person who is age 65 or older, and:

1. an active Person; or

2. a Dependent of an active Person.

For Retired Persons and Their Dependents (if insured under this Policy)

This Policy will be a Secondary Plan to Medicare for a Covered Person who is age 65 or older, and:

1. a retired employee; or

2. a Dependent of a retired employee.

To determine the amount of reduction for purposes of COB, the Company will include all benefits for which the Covered Person is eligible under Medicare Parts A and B. Such benefits will be considered payable under Medicare, whether or not the Covered Person has registered for Part A benefits, or enrolled for Part B benefits.

Medicare Benefits Due to Total Disability

A Covered Person may become entitled to Medicare benefits prior to age 65 if he or she is totally disabled or has end stage renal disease. The following rules apply with respect to COB with Medicare due to total disability or end stage renal disease prior to age 65. Upon attainment of age 65, the rules for COB with Medicare at age 65 will apply.

During Medicare Waiting Period

This Policy will be a Primary Plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease.

After Medicare Waiting Period

After the Medicare waiting period has been met, and the Covered Person is entitled to Medicare benefits, this Policy will be:

1. a Primary Plan to Medicare for a Covered Person who is an active Person, or his or her Dependent, and entitled to Medicare benefits due to total disability other than end stage renal disease; and

2. a Secondary Plan to Medicare for a Covered Person who is:

   a. an active Person, or his or her Dependent, who is entitled to Medicare benefits due to end stage renal disease; or

   b. a retired Person, or his or her Dependent, who is entitled to Medicare benefit due to total disability or end stage renal disease.

Electing Medicare as Primary Plan

A Person or Dependent who is entitled to Medicare benefits at age 65, or as a result of total disability, may elect to have Medicare as the Primary Plan by giving notice to the employer. If a Person or Dependent elects Medicare as their Primary Plan, their health insurance under this Policy will cease.

"Medicare" means the medical benefits provided by Title XVIII of the Federal Social Security Act, as amended to date.

SECTION 11 - CLAIM PAYMENT

Notice and Proof of Claim

Notice and Claim Forms

In order to receive a claim form for filing a claim, written notice of a claim must be given to the Claim Administrator within 90 days after the date of loss which is covered under this Policy. Failure to give notice within such time will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice, and that notice is given as soon as it is reasonably possible to do so. If claim forms are available from the Policyholder, written notice of a claim is not required in order to receive a claim form.

Upon receipt of the written notice of claim, the Claim Administrator will provide claim forms for filing proof of a claim to the Policyholder for delivery to the Covered Person, or to the Covered Person making a claim. If the Covered Person does not receive the claim forms within 15 days after the Company receives the notice of claim, the Covered Person making the claim will be deemed to have complied with the requirements shown under *Proof of Claim* as described below, provided the Covered Person sends the Claim Administrator written proof of claim which includes the information required under *Proof of Claim*.

Proof of Claim

Proof of the loss for which a claim is made must be given to the Claim Administrator no later than 90 days after the date of loss. A claim will not be reduced or denied for failure to provide proof within this time, if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one year after the date of loss, unless the Covered Person was legally unable to notify the Claim Administrator.

The proof of claim must include all information necessary for the Claim Administrator to determine:

1. what the loss is;
2. the date of the loss;
3. the cause of the loss; and
4. what other group or group-type "Plans", as defined under the ***COORDINATION OF BENEFITS*** provision, that the Covered Person for which claim is made is also covered.

The Claim Administrator may require, as part of the proof, authorization to obtain medical and non-medical information. The Claim Administrator will notify the Covered Person of any additional information required to process a claim.

Examination and Autopsy

The Claim Administrator, at its own expense, has the right and opportunity to:

1. have the Covered Person whose claim is pending examined by a Doctor of its choice. This right may be used as often as reasonably required; and

2. have an autopsy performed, if it is not prohibited by law.

Payment of Benefits

All benefits that are payable under this Policy will be paid within 60 days as soon as the Claim Administrator receives satisfactory proof of the claim. No benefit will be paid for any charge, or portion of a charge that is discounted, waived or rebated by a provider simply because the Covered Person has insurance. The Claim Administrator shall have the right to recover any excess benefits paid for charges which were discounted, waived or rebated from the Covered Person or the provider.

To Whom Benefits Are Payable

All benefits are payable to the Person. However, the Claim Administrator may pay all or a part of the benefits to the institution or individual providing Treatment. The Person may, by written assignment, request that benefits be paid to a provider, or to themselves, but not later than at the time proof of claim is given to the Claim Administrator.

If benefits are to be paid to a minor or other Covered Person who, in the Claim Administrator's opinion is not able to give a valid receipt for any payment due him or her, the Claim Administrator will make payment to that Covered Person's legal guardian. If no legal guardian has been appointed, the Claim Administrator may, at its option, make payment to the individual or institution who appears to be entitled to the payment. Payment so made shall discharge all liability under this Policy with respect to that amount.

Claim Denial and Appeal

If all or a part of a claim is denied, the Claim Administrator will send a written notice which explains the reasons for the denial. If the Covered Person does not agree with the denial, he or she may make a request for review of the claim. Such request must be in writing to the Claim Administrator. If the Covered Person requests a review, he or she may:

1. request and receive copies of all pertinent documents on which the claim decision was based. A written approval may be required to release confidential records, such as medical records; and

2. submit additional information to support the claim, including issues and comments in writing.

The Claim Administrator will review and make a decision on the claim within 60 days from the later of:

1. the date the written request for review was received by the Claim Administrator; or

2. the date all additional information and comments are received by the Claim Administrator.

The Claim Administrator will notify the Covered Person of its decision in writing, and will include clear and specific reasons for the decision.

Additional Appeal Rights

If all or part of the claim is still denied, the Covered Person has the right to appeal directly to the Policyholder. These rights are described in the ERISA Rights Section of the Person's booklet or Summary Plan Description.

Legal Actions

A claimant, or the claimant's authorized representative cannot start any legal action with respect to a claim:

1. until 60 days after proof of claim as required above has been given; nor

2. more than 3 years after the time proof of claim is required.

Right to Recover

Benefits Paid in Error or Fraud

The Company has a right to reimbursement for benefits paid under this Policy, if it is found that such charges were paid in error.

The Company has a right to recover any benefits paid under this Policy as a result of fraudulent claims submitted for Treatment not rendered or purchased.

Third Party Liability

The Company has a right to reimbursement for benefits paid under this Policy, and the right to a lien on any recovery from a third party, if the third party is determined to be liable for such charges.

If it is determined that an Injury or Illness was the result of an intentional or unintentional act, or failure to act, of a third party, benefits for:

1. medical or dental charges; or

2. loss of earnings;

will be paid under this Policy only on the condition that the Covered Person (or his or her legal representative) shall agree in writing that:

1. the Company shall be entitled, to the extent of such payment, to the proceeds of any payment, settlement or judgment that may result from the exercise of any rights of recovery of such Covered Person against any individual or organization legally responsible for such charges; and

2. the Company shall have a lien to the extent of such payment, notice of which may be filed with the individual whose act caused the Injury or Illness, his or her agent, or a court having jurisdiction in the matter.

Reimbursement to the Company will be to the extent of the benefits paid. However, the reasonable pro rata expenses, such as lawyers' fees and court costs incurred in effecting the third party payment, may be deducted from the reimbursement.

The reimbursement agreement will be binding upon the Covered Person (or his or her legal representative) even if:

1. the payment received from the third party, or its insurer, is the result of:

   a. a legal judgement; or

   b. an arbitration award; or

   c. a compromise settlement; or

   d. any other arrangement; or

2. the third party, or its insurer, has not admitted liability for the Injury or Illness; or

3. the medical or dental expenses, or loss of earnings are not itemized in the third party payment, settlement or judgement.

If the Covered Person does not exercise his or her right of recovery, the Company has the right to be subrogated to the extent of any benefits paid under this Policy, to the proceeds of any settlement or judgement effected against a third party and resulting from the exercise of any rights of recovery which the Covered Person may have against any individual or organization.

At the Company's request, a Covered Person must execute and deliver all instruments, and take such other action as the Company may require to implement this provision. The Covered Person shall do nothing to prejudice the rights given the Company by this provision without its consent.

SECTION 12 - GENERAL PROVISIONS

The Policy

This Policy, its amendments and endorsements, the Policyholder's application, a copy of which is attached, and any individual applications, **if any**, for Persons, form the entire contract between the Company and the Policyholder.

Individual Certificates of Insurance

The Company will issue to the Policyholder, individual Certificates of Insurance to be delivered to each insured Person. The Certificate will state:

1. a summary of the benefits for which the Person and his or her Dependents are insured, including conversion rights, **if any**;

2. to whom the benefits are payable; and

3. any other conditions of this Policy that affect Persons.

If there is a difference between the provisions of this Policy and a Certificate of Insurance, the provisions of this Policy will govern.

New Entrants

Eligible new Persons may be added from time to time, to the group or class of individuals originally insured, in accordance with the terms and conditions of this Policy.

Statements; Incontestability of Insurance

All statements made by the Policyholder or a Person are considered to be representations and not warranties. No such statement may be used to contest the validity of this Policy, or a Person's insurability after the insurance has been in force prior to the contest for two years during the Person's lifetime unless:

1. it is in writing and signed by the Policyholder or the Person; and

2. a copy of the statement is given to the Policyholder, the Person or his or her beneficiary.

The Policy

This Policy will not be contested after it has been in force for two years from its date of issue, except for non-payment of premiums.

The Person

No statement made by the Person will void or reduce his or her insurance benefits provided under this Policy, unless it is contained in a written instrument signed by the Person. This provision does not preclude the Company from asserting defenses based upon the Person's ineligibility for insurance, non-payment of premium, or fraud.

Insurance Information

The Policyholder will provide the Company with all information it needs to carry out the terms of this Policy. The Company will have the right to inspect all books and records which relate to this Policy, whether such books and records are in the possession of the Policyholder or its designated representative. The Company may inspect such books and records at any reasonable time while this Policy remains in force, or after its termination.

If a clerical error is made with respect to individuals insured under this Policy, such error will not:

1. terminate a Person's insurance that would otherwise remain in force; or

2. continue insurance on an individual that would otherwise be terminated.

Upon discovery of a clerical error, an adjustment may be made to the premium.

Misstatement of Age

If the age of a Person has been misstated, the Company will use the Person's true age to determine:

1. the effective date or termination date of the Person's insurance under this Policy;

2. the amount of insurance; and

3. any other rights or benefits affected by age.

Based on the true age, the Company may make an adjustment to the premiums, the benefits, or both.

Policyholder or Designated Representative Not an Agent

The Policyholder, or its designated representative, will not be considered to be the agent of the Company for any purpose under this Policy.

Authority of Agents

Agents are not authorized to:

1. modify or waive this Policy; or

2. in event of lapse, to reinstate this Policy; or

3. extend the time for the payment of any premium due.

Only an Officer of the Company has the authority to change, modify or waive the provisions of this Policy, and then only in writing. Such change will be evidenced by endorsement on this Policy, or by amendment to this Policy signed by the Policyholder and the Company.

Workers' Compensation Insurance

This Policy is not issued in lieu of, nor does it affect any requirement for insurance by any Workers' Compensation Insurance Law, Occupational Disease Law or similar laws.

Premium Payment

All premiums must be paid on or before the Premium Due Date shown on the face page of this Policy, at the Home Office of the Company, or at any office authorized by the Company to accept them. The total amount of premium due will be based on:

1. the premium rates in effect; and

2. the number of lives insured and/or the volume of insurance in force, including adjustments, if any.

Premium

The initial premium rate **(Billed Rates)** will be as follows:

FORM OF INSURANCE	PREMIUM RATE
Medical Benefits	
per Person	$137.04
per Dependent Unit	$178.12

Grace Period

After the initial premium has been paid, the Policyholder is entitled to a grace period of 31 days for the payment of any premium due. If the required premium is not paid by the Premium Due Date, this Policy will terminate on the earlier of following dates:

1. the end of the grace period; or

2. the date of termination elected by the Policyholder, for which the Company was given prior written notice in accordance with the terms of this Policy.

The insurance under this Policy will continue in force during such grace period, or until the date of termination elected by the Policyholder, if earlier. The Policyholder will be liable for a pro rata premium for the time this Policy was in force during the grace period.

Dividends

This Policy will participate annually in the distribution of divisible surplus. Such surplus will be determined and apportioned by the Company at the end of each Policy year, provided this Policy has been continued in force by the payment of all premiums due to the end of the Policy year. To determine the divisible surplus, the Company will combine the financial experience of this Policy with the financial experience of all other group policies issued to the Policyholder by the Company.

All dividends will be either:

1. paid to the Policyholder in cash; or

2. at the request of the Policyholder, applied toward the payment of premiums.

If Persons contribute toward the cost of the insurance, and if the aggregate of any dividends payable exceed the Policyholder's aggregate share of the cost, such excess shall be applied by the Policyholder for the sole benefit of the Persons.

Payment of any dividend to the Policyholder will completely discharge the liability of the Company with respect to any dividend so paid.

Changes

Premium Rate Change

The Company reserves the right to change the premium rates on any Premium Due Date on or after the first Policy anniversary date by giving at least 60 days advance written notice of the change to the Policyholder. The Company will not change premium rates more than once in any Policy year or rate guarantee period.

However, this provision does not prohibit the Company from changing premium rates on any Premium Due Date by giving at least 60 days advance written notice of the change to the Policyholder as a result of:

1. a change in benefit plan design or eligibility requirements; or

2. a material change in the composition of the group.

Policy Changes

The benefits, terms or conditions of this Policy may be changed:

1. on any Premium Due Date, by a written agreement between the Policyholder and the Company; or

2. on any date, when such change is required by law.

No such change will be effective until approved by an Officer of the Company. In all matters regarding this Policy, the Policyholder acts for the Persons insured under this Policy.

Policy Termination

Termination by the Policyholder

The Policyholder may cancel this Policy at any time by giving written notice to the Company at least 60 days in advance of the requested termination date. Termination will be effective on the later of:

1. 60 days from the date the Company receives the written notice; or

2. the date set by the Policyholder in the notice;

unless terminated earlier by the Company, as described immediately below.

Termination by the Company

The Company may terminate this Policy, or any portion of this Policy:

1. as provided under *Grace Period* in this Section for non-payment of premium; or

2. on any Premium Due Date, if fewer than 25 Persons are insured under this Policy, by giving the Policyholder written notice of termination at least 60 days prior to the date of termination; or

3. on any renewal date, by giving the Policyholder written notice of termination at least 60 days prior to the renewal date.

The effective date of termination will be the earliest of these dates that apply.

Notice of Policy Termination to the Policyholder

For New York Residents: If the Company terminates this Policy, the Company will give the Policyholder a notice of termination, as required by NYCRR, Title II, Part 55, which will include information pertaining to the Policyholder's obligation to notify each certificateholder covered under this Policy of this Policy's termination.